Senate

General Assembly

File No. 613

January Session, 2015

Substitute Senate Bill No. 993

Senate, April 13, 2015

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING FACILITY FEES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-508c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Affiliated provider" means a provider that is: (A) Employed by a hospital or health system, (B) under a professional services agreement with a hospital or health system that permits such hospital or health system to bill on behalf of such provider, or (C) a clinical faculty member of a medical school, as defined in section 33-182aa, that is affiliated with a hospital or health system in a manner that permits such hospital or health system to bill on behalf of such clinical faculty member;

(2) "Campus" means: (A) The physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not

strictly contiguous to the main buildings but are located within two hundred fifty yards of the main buildings, or (B) any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus;

(3) "Facility fee" means any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee;

(4) "Carrier" means each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

[(4)**]** (5) "Health system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

[(5)**]** (6) "Hospital" has the same meaning as provided in section 19a-490;

[(6)**]** (7) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided;

[(7)**]** (8) "Professional fee" means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility; and

[(8)**]** (9) "Provider" means an individual, entity, corporation or health care provider, whether for profit or nonprofit, whose primary purpose is to provide professional medical services.

(b) If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by the provider;

(2) (A) The amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(c) If a hospital or health system charges a facility fee without utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written

notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that may be in addition to and separate from the professional fee charged by a provider;

(2) (A) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (B) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility was not hospital-based; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(d) The written notice described in subsections (b) and (c) of this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges.

(e) (1) For nonemergency care, if a patient's appointment is scheduled to occur ten or more days after the appointment is made, such written notice shall be sent to the patient by first class mail, encrypted electronic mail or a secure patient Internet portal not less than three days after the appointment is made. If an appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, such notice shall be hand-delivered to the patient when the patient arrives at the hospital-based facility.

(2) For emergency care, such written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, as amended from time to time, or is

determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is unconscious, under great duress or for any other reason unable to read the notice and understand and act on his or her rights, the notice shall be provided to the patient's representative as soon as practicable.

(f) Subsections (b) to (e), inclusive, of this section shall not apply if a patient is insured by Medicare or Medicaid or is receiving services under a workers' compensation plan established to provide medical services pursuant to chapter 568.

(g) A hospital-based facility shall prominently display written notice in locations that are readily accessible to and visible by patients, including patient waiting areas, stating that: (1) The hospital-based facility is part of a hospital or health system, and (2) if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based facility was not hospital-based.

(h) A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, Internet web sites and stationery.

(i) Notwithstanding the provisions of this section, on and after October 1, 2015: (1) No hospital or health system shall charge a facility fee (A) for services classified by the Medicare Payment Advisory Commission as Group 1 or Group 2 ambulatory payment classification in its June 2013 Report to Congress: Medicare and the Health Care Delivery System, as updated from time to time, (B) for services classified as evaluation and management, or (C) of more than one hundred dollars for services received by a patient that is uninsured; and (2) each carrier shall provide coverage for facility fees as medical expenses.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-508c

Statement of Legislative Commissioners:
In Section 1(a)(4) "any group health insurance policy" was changed to "any individual or group health insurance policy" and "subdivisions (1), (2), (4), (6), (10), (11) and (12)" was changed to "subdivision (1), (2), (4), (11), (12)" for accuracy.

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 $	FY 17 $
State Comptroller - Fringe Benefits	GF - Potential Savings	See Below	See Below
UConn Health Center	Other - Revenue Loss	Up to $109 million	Up to $145 million

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 16 $	FY 17 $
Various Municipalities	Potential Savings	See Below	See Below

Explanation

The bill prohibits hospitals from charging facility fees for certain outpatient services provided in a hospital based facility, effective October 1, 2015. This change will result in a significant revenue loss to the John Dempsey Hospital (JDH) at the University of Connecticut Health Center (UCHC). As the current statute defines "facility fee" as a fee intended to compensate a hospital for operational expenses, it appears the bill could preclude UCHC from charging for any eligible outpatient services provided at JDH. In FY 15, it is anticipated that a total of $145 million in eligible outpatient services will be provided at JDH. Should UCHC be unable to find a method by which to bill for these services rendered, a significant revenue loss will result.

The bill may result in a savings to the state employee and retiree

health plan and fully insured municipalities[1] to the extent that eligible outpatient services provided at a hospital facility are not required to be covered by the plans; based on both the current statutory definition of "facility fee" and the exclusions in the bill.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

OLR Bill Analysis
sSB 993

AN ACT CONCERNING FACILITY FEES.

SUMMARY:

This bill prohibits hospitals and health systems from charging a facility fee for certain services. It prohibits them from charging a facility fee of over $100 for other services they provide to uninsured patients. Finally, it requires health carriers to provide coverage for facility fees as medical expenses.

Each of these provisions applies (1) on and after October 1, 2015 and (2) despite the existing notice requirements for hospitals or health systems that charge facility fees.

For the complete prohibition on facility fees, the bill applies to:

1. evaluation and management services and

2. a specific list of ambulatory services classified as group 1 or 2 and identified in a 2013 report by the Medicare Payment Advisory Commission (MedPAC) (see BACKGROUND).

Under the bill and existing law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate from the provider's professional fee. A "health system" is a (1) parent corporation of one or more hospitals and any entity affiliated with that corporation (through ownership, governance, membership, or other means) or (2) hospital and any affiliated entity.

The bill's insurance coverage requirement applies to insurers, HMOs, hospital or medical service corporations, or other entities

delivering, issuing, renewing, amending, or continuing individual or group health insurance policies in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: Upon passage

BACKGROUND

Facility Fee Notice Requirements

By law, hospitals or health systems must notify patients when they charge facility fees for outpatient services at hospital-based facilities. The facility must notify a patient in writing (1) that the facility is part of a hospital or health system that charges a facility fee that may be in addition to the provider's professional fees; (2) about the patient's potential financial liability (including in some circumstances the amount); and (3) that the patient should contact his or her health insurer for additional information. These requirements do not apply to Medicare or Medicaid patients or those receiving services under a workers' compensation plan.

The law also requires hospital-based facilities that charge facility fees to prominently display signs indicating that the patient may incur more financial liability than if the facility were not hospital-based.

MedPAC Report

In a June 2013 Report to Congress (*Medicare and the Health Care Delivery System*), MedPAC identified 66 services (in two groups) provided in hospital outpatient departments and offices that are frequently performed in physicians' offices. The services were identified by ambulatory payment classification.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 21 Nay 7 (03/25/2015)